

Comment

Contributors to this section are asked to make their comments brief and to the point. Tables and figures should be included only if absolutely essential and no more than five references should be given.

El Zahrawi (936-1013 AD), The father of operative surgery

I was interested to read Mr. Nabri's recent paper (*Annals*, March 1983 vol. 65, p. 132) claiming the paternity of operative surgery for this 10th Century Arab surgeon.

Nearly two millennia before El Zahrawi was born, the Indian Surgeon Susruta practised and taught the art of surgery at the University of Varanasi, on the banks of the river Ganges. Susruta's encyclopaedia of surgery, the *Susruta Samhita* was written in Sanskrit, and is one of the most comprehensive of Ayurvedic surgical texts. It was translated into Arabic before the end of the 8th Century AD, entitled *Kitab-i-Susrud*, by Abillsaibial (1)—so it is quite possible that El Zahrawi knew of it. More recent translations—into Latin by Hessler, German by Muller and English by Bhisagratna—are available today.

The *Samhita*, written between the 6th and 8th Centuries BC, gives detailed descriptions of Susruta's surgical instruments (2). The list of operations accurately described by him would do justice to a modern textbook of operative surgery—rhinoplasty, vesical lithotomy, foetal craniotomy for obstructed labour, cataract removal, tonsillectomy, laparotomy with closure of intestinal wounds etc.

It is pertinent here to quote William Hunter (1718-83), as cited by Gordon (3): '... Arab medicine was founded on translations from Sanskrit treatise, and, in turn, European medicine down to the 7 century was based upon the Latin version of the Arabian translation'.

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- 2 Wijesinha S, Wickremasinghe C. Surgery and Hospitals in Ancient Sri Lanka and India. *J R Surg Edinb* 1981;26:245-249
- 3 Gordon BL. Medicine throughout antiquity. Philadelphia E A Davis Co. 1949 p. 323

A simple stoma wafer cutter

There is no doubt that a cheap and easy to use wafer cutter would be of benefit to a great number of patients and I applaud Martin Clifton's efforts (*Annals*, May 1983, Vol. 65, p. 172). From the description of the cutters, however, I wonder whether all patients will be able to forge clean holes through the wafers simply by hand pressure.

One patient I treated used a similar device but found a sharp blow with a hammer gave a perfect result. I have been working on a stoma cutter using a lever principle which I hope to demonstrate later in the year.

However, if the simple arrangement of cutters described by Mr Clifton is workable by all patients, even the elderly and arthritic, it will certainly bring comfort to a large number of ostomy patients who at the present time are forced to make holes with scissors. Their efforts are often awkward and not always successful.

Finally, have Seward Surgical fixed a price?

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I was pleased to hear that someone else was also interested in producing a simple means for cutting stoma wafers and I agree entirely with Mr McDonald that to be of value the technique should be both simple and inexpensive.

The reason for choosing this particular design of circular cutter rather than some of the more exotic shapes which are sometimes necessary was that a circular cutting movement reduces the pressure needed to cut the wafer to a minimum so that 'a sharp

blow with a hammer' is no longer needed. Oval or figure of eight shapes can easily be achieved by cutting overlapping holes. If an oval cutter had been used then, because rotation would not be possible, much more pressure would be necessary.

I am informed by the manufacturers that the anticipated price of a set of five cutters in a plastic box will be £14.50, the cost, therefore, for an individual patient provided with a single cutter without the plastic box would probably be in the region of £2.00.

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A study of colovesical fistulae in a district hospital

In this article (*Annals*, July 1983, vol 65 p. 221) Messrs Morrison and Addison reported that radiological examination showed evidence of fistulae formation in 55% of the patients. This was achieved in barium enema examinations. Cystography was only performed in two patients of the group and the fistula was seen in one. Intravenous urograms showed gas in the urinary bladder in two patients and a filling defect in three. We would like to caution that we presented an original sign which we called 'Beehive on the Bladder' to the *Annals* in 1981 (1). We reported the finding of a pyramidal shaped outline which was always seen at the site of the fistulous tract with the fistula connected to its base. Since then we have been able to study 20 patients in whom the sign was seen: colorectal carcinoma (4 patients) colovesical fistulae (6 patients) and diverticular disease of the colon (10 patients) with no fistula formation. In all these patients the sign was seen and we presented these findings to BAUS in June 1983, at the meeting in Harrogate.

The successful technique to show the sign in cystography was to avoid filling the bladder completely and to screen the bladder obliquely. This technique was successful in demonstrating the sign in all patients. We feel that the sign is valuable in demonstrating the patients with occult bowel disease leading to their presentations with urinary symptoms arising from bladder involvement. The sign was seen in patients prior to fistulae formation.

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The fate of the below knee amputee

I read with satisfaction about the aggressive approach to preservation of the knee joint if at all possible (*Annals*, July 1983, vol 65 p. 230); in the geriatric unilateral lower limb amputee it transcends issues such as prosthetics and gait training. The advantages to the elderly amputee of a below knee stump are overwhelming; he/she should be able to make use of a patellar tendon bearing prosthesis, which is donned like a sock requiring only one buckle to secure it in position. A reliable objective test which assesses skin viability in chronic ischaemia would be invaluable to the surgeon performing a below knee amputation.

The transcutaneous oxygen monitor, developed as a non-invasive method of measuring arterial oxygen tension in neonates, has recently been used in adult intensive care units and been applied to measurement of skin ischaemia in peripheral vascular disease. It is possible to obtain direct readings of the $TcPo_2$ by a polarographic method, and by heating the skin to the point of maximal vasodilatation the $TcPo_2$ can be used as a practical method of continuous arterial oxygen pressure monitoring (1). Measurements of the $TcPo_2$ in the leg at the site of amputation in patients with peripheral vascular disease show that a preoperative level of 40 mm Hg or over (normal 45 mm to 95 mm Hg with a mean of 70 mm Hg) at an electrode temperature of 44 °C is necessary for the stamp to heal (2).